



THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
239 CAUSEWAY STREET, SUITE 200
BOSTON, MA 02114
800-414-0168
617-973-0800
www.mass.gov/dph/boards

BOARD OF RESPIRATORY CARE
Application for Full License
All Questions Must Be Completed
FEE: \$175.00 check or money order

1. Applicant Name: _____
(Last) (First) (Middle)
 - a. Limited Permit Number (if applicable): _____
 - b. Maiden Name/Other Name (if applicable): _____
(Last) (First) (Middle)
2. Address: _____
(No.) (Street) (Apt. #)

(City/Town) (State) (Zip Code)
3. Most Recent Previous Address: _____
(No.) (Street) (Apt. #)

(City/Town) (State) (Zip Code)
4. Telephone Number(s) Day: _____ Evening: _____
5. Date of Birth: ____/____/____ (mm/dd/yyyy)
6. Place of Birth: _____
7. Sex: M F 8. Height: _____ 9. Weight: _____ 10. Eye Color: _____
(Circle One)
11. Mother's Maiden Name: _____

FOR BOARD USE ONLY

Cash Number: _____ License Number: _____
Limited Permit Number: _____

12. Social Security Number (**Disclosure is mandatory**) : _____ - _____ - _____
Pursuant to G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax and child support laws of the Commonwealth.

13. Massachusetts Employer Name: _____
(if applicable)
Address: _____
(Street) (City) (State) (Zip Code)

14. Education:
Respiratory Care Program Name/Location: _____
Degree/Certificate awarded: _____ Date of Graduation: ____/____/____
(mm/yyyy)
Provide official documentation of completion of an accredited respiratory therapy education program. Documentation must be in a school-sealed envelope. Transcripts may be mailed directly to the Board.

15. Certification: Are you credentialed by the National Board for Respiratory Care (NBRC)?
CRT Yes ____ No ____
RRT Yes ____ No ____
Arrange for official NBRC Request for Verification of Credentials to be sent directly to the Board from NBRC.

16. List all professional licenses or certifications currently or previously held in any other states or jurisdictions.

Submit a certificate of standing from each state or jurisdiction in a signed sealed envelope. Certifications may be mailed directly to the Board.

Lic. No.	Profession	Issuing Jurisdiction
_____	_____	_____
_____	_____	_____
_____	_____	_____

Use additional pages if necessary.

If you answer YES to any of the following questions attach a separate sheet explaining each one.

17. Have you ever been a defendant in a Medical Malpractice claim?

Yes ____ No ____

Include claim number, date(s) and current status of claim with your explanation.

18. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes ____ No ____

19. Has any licensing or certification board located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ____ No ____

20. Have you voluntarily surrendered or resigned any professional license to a licensing board or certification board within the past 10 years?

Yes ____ No ____

21. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor traffic violations for which a fine of \$100 or less was imposed.
Yes _____ No _____

22. Pursuant to GL c. 62C, s. 49A, I have filed all Massachusetts tax returns and paid all Massachusetts child support and taxes required by law?
Yes _____ No _____

If NO, attach a complete explanation, copy of payment agreements, etc.

23. Pursuant to G.L. c. 119, s. 51A and G.L. c. 112, s. 1A, I certify that I will fulfill my obligation to report the abuse or neglect of children.
Yes _____ No _____

AFFIDAVIT

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Respiratory Care any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Respiratory Care to release information contained in this application in association with its processing.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board (CHSB) for access to conviction and pending criminal case data. As an applicant for authorization to practice as a Respiratory Therapist, I understand that a criminal record check may be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information provided in this application pursuant to G.L. c. 112, ss. 23R through 23BB is correct to the best of my knowledge.

I agree to abide by the rules and regulations for licensing in Respiratory Care as defined in and promulgated pursuant to G.L. c. 112, ss. 23R through 23BB.

I attest that the statements made herein are truthful and are made under the pains and penalties of perjury.

Signature of Applicant _____ **Date** _____

**Attach a recent
2x2 passport style
photo**

Notary Name: _____

Commission expires: _____

[Seal]

A copy of the statute & regulations pertaining to Respiratory Care is available on the Board's web site at www.mass.gov/dph/boards or from the State House Bookstore, Room 116, State House, Boston, MA 02133. Phone: (617) 727-2834. The statutes for Respiratory Care are Massachusetts General Laws, Chapter 13, section 11B and Chapter 112, sections 23R through 23BB. The Board regulations are 261 Code of MA Regulations, sections 2.00 through 5.00.

Attach a non-refundable fee of \$175.00 (check or Money Order) payable to the Commonwealth of Massachusetts.